Certificate No: _____

Expiration Date: _____

MENTAL HEALTH PROFESSIONAL PERSON

Application For Certificate Renewal

A. Name: _____ Date: _____

_____ Phone: _____

Street Address

_____

City State Zip

Work Address: _____ Phone: _____

Name of Organization

_____

Address

_____

City State Zip

B. Education and Training

List below any education and training you received *since your last certification review* and which is relevant to your application for renewal (this includes continuing education units). The information listed under each heading below is required for certification renewal. In the event of an audit, you will be asked to supply either the course agenda or a certificate of completion. If you earned a college or university degree during this time, an **official transcript should be submitted directly to the Certification Committee by the school**.

Name & Address of School or Training Operations	Subject	Credits	Date

Mental Health Professional Person Renewal Application

Name of Applicant: _____

Certificate No. _____

C. Employment History

Use the space below and/or a separate sheet of paper to list all employment you have had in the last three (3) years and describe your duties. Be sure to include the organizations with whom you were employed, and the dates employed in each position.

Mental Health Professional Person Renewal Application

Name of Applicant: _____
Certificate No. _____

D. Current Employment Information

Employer: _____ Phone: _____

Address: _____

Name of Supervisor: _____

Dates of Employment: _____ through _____

Job Title: _____ Full Time ☐ Part Time ☐

Is this employer an agency, organization, or unit within an organization in which the primary purpose is the treatment of mental disorders?

☐ Yes ☐ No ☐ Not Sure

The percentage of your time in this job providing direct mental health treatment to seriously mentally ill **persons:** _____ %

The percentage of your time in this job spent evaluating persons for possible serious mental illness: _____ %

The percentage of your time in this job spent doing long-term treatment planning for seriously mentally ill persons: _____ %

Other Major Duties:

_____ _____ %

_____ _____ %

_____ _____ %

_____ _____ %

_____ _____ %

_____ _____ %

_____ _____ %

_____ _____ %

_____ _____ %

_____ _____ %

Mental Health Professional Person Renewal Application

Name of Applicant: _____
Certificate No. _____

Describe briefly, in narrative form, the nature of the work you perform for this employer.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

TO THE APPLICANT:

1. If you are employed, have your supervisor sign below prior to returning this form.

2. If you are in private practice, or are the head of your organization, **sign below to indicate that the information provided is true to the best of your knowledge and to certify that you continue to perform satisfactorily in direct treatment of mentally ill persons or direct supervision of mental health treatment programs**.

TO THE EMPLOYER: The person named above is an applicant for re-certification by the State of Montana as a Mental Health Professional Person. Montana law gives to Mental Health Professional Persons a number of responsibilities, including the authority to provide expert testimony regarding the need for institutionalization at commitment hearings and to develop and supervise treatment plans for individuals in mental health inpatient facilities. **Your signature below indicates that you have read the information provided by the applicant in Section D of this of this form and that you certify that the information is true to the best of your knowledge and that this applicant continues to perform satisfactorily in direct treatment of mentally ill persons or in direct supervision of a mental health treatment program**.

Signature of Supervisor: _____
(or Applicant in private practice)

Printed Name and Title: _____

Date: _____

Return this form to: Professional Person Certification Committee
Addictive & Mental Disorders Division
P.O. Box 202905
Helena, MT 59620-2905